		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/25/2010 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		185352	B. WING _		08/1:	2/2010
NAME OF F	PROVIDER OR SUPPLIER	`	STF	REET ADDRESS, CITY, STATE, ZIP CODE		WE010
STANTO	N NURSING CENTER	<u> </u>		1 DERICKSON LANE STANTON, KY 40380	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	S	F 000	F280	****	····
. '	through 08/12/10, a was conducted 08/	irvey was conducted 08/10/10 ind a Life Safety Code Survey 10/10. Deficiencies were cited ope and Severity of an "E".	ı	1.Resident #4 Comprehensive Ca updated to reflect every one hour repositioning schedule on 8/12/20 Director of Nursing. Resident #4 did not experience an	turning and 10 by the	-
F 280 SS=D	483.20(d)(3), 483.1	0(k)(2) RIGHT TO NNING CARE-REVISE CP	F 280	skin status as of 8/12/2010.	_	
	incompetent or other incapacitated under participate in planni changes in care and A comprehensive cawithin 7 days after to comprehensive assinterdisciplinary teal physician, a register	the laws of the State, to ng care and treatment or directment. are plan must be developed he completion of the essment; prepared by an m, that includes the attending red nurse with responsibility		2All residents have the potential to An audit of all Comprehensive Completed by the Director of Nursing(D.O.N.),RDCS(Regional Clinical Services) and /or the Unit (U.M.)by 9/20/2010 to identify an Comprehensive Care Plan not revi Any Comprehensive Care Plan no and/or not reflective of individual immediately corrected by 9/21/2010 DON and /or UM.	Director of Manager y ised as needs trevised needs will be	11 ed. e
	for the resident, and disciplines as determined to the extent put the resident, the resident, the resident representative and revised by a tea each assessment.	d other appropriate staff in mined by the resident's needs, racticable, the participation of ident's family or the resident's and periodically reviewed am of qualified persons after	CEN	3.Regional Director of Clinical Serwho is Wound Care Certified, to r DON,UM, ETD(Education Trainir and licensed nurse responsible for management regarding policy and turning and repositioning schedule procedure for individualized turning the service of the procedure and policy a for development and implementation of the procedure for development and development an	re educate the good pirector) skin program procedure for policy and and procedure for of the	e n or
	Based on observation review it was determined the Compression of the C	on, interview, and record himself, interview, and record himself, interview and record himself,		9/15/20 0. DON and /or ETD to re educate all personnel regarding policy and proturning and repositioning schedule, procedure for individualized turning repositioning schedule and policy afor development and implementation individualized Comprehensive Caracalates to all plans of care by 9/22/2	nursing cedure for policy and g and and procedur on of the	re
BORATORY	DIRECTOR'S OR PROVIDE	ER/SVPPCIER REPRESENTATIVE'S SIGN	ATURE	, TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) genotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		& WEDICAID SERVICES				OMB NO	0938-0391
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION NG	(X3) DATE SI COMPLE	URVEY
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	PROVIDER OR SUPPLIER IN NURSING CENTER			3	REET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380	1 00/ 1/	
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	UI O BE	(X5) COMPLETION DATE
	1. Observations dur 08/11/10, at 9:30 AM lying on the bed and his/her left side. Fu AM, 11:53 AM, and #4 continued to be is bed. Review of Resident an admission date of healed Pressure Uld End-Stage Alzheime Review of the Quart dated 07/09/10, rever extensive assist of to and transfers. Furth revealed the patient (1) Stage IV Pressur Resident Assessment (RAPS) dated 05/19/ triggered for Pressur required extensive assincentinent of bowel is pressure ulcers. Review of the Compro 08/03/10, revealed the entitied, "Skin Integrified and Treatment Plan of nterventions reveale- turned and reposition no documented evide #4 was to be turned an interview on 08/11/10 Nursing Assistants (C	ing a skin assessment on of revealed the resident to be it being turned by staff to rither observations at 10:55 12:45 PM revealed Resident ying on his/her left side on the wing on his/her left side on the stage of the stage o	F2		DON and for UM to visually audit to ensure turning and repositioning per individualized Comprehensive that Comprehensive Care Plan is coweek x 2 weeks, then 3 x week x 2 beginning week of 9/20/2010. RDCS to audit ten(10) entire Comp Care Plans Q month beginning wee 9/20/2010 to ensure POC revised at needed to provide individualized comonths. 4. All audit findings to be presented Assurance Committee (Administration of Nursing), Unit Manager, Licensor responsible for skin program mana Enrichment Director, Dietary Servi Medical Director and Social Servi for review and revision if needed be and then monthly until resolved be of 9/20/2010.QA Committee to revof all audits and review corrections order to ensure comprehensive care correct and revisions made per resindividual needs. 5. Date of Compliance 9/23/2010	is occurring Care Plan a brrect 5x weeks brehensive ek of and updated are x 3 I to Quality tor, Directo ed Nurse gement, Liti ices Manag ces Directo oi monthly x ginning we view finding s made in e plans are	as as feer, as 2 ek

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/25/2010 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A BUILDING B. WING 185352 NAME OF PROVIDER OR SUPPLIER 08/12/2010 STREET ADDRESS, CITY, STATE, ZIP CODE STANTON NURSING CENTER 31 DERICKSON LANE STANTON, KY 40380 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X6) COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) F 280 Continued From page 2 F 280 The CNAs stated Resident #4 was to be turned every hour. They indicated there was a paper taped to the back of the resident's door that stated the turning schedule. Review of the paper F281 the CNAs showed the surveyor revealed, 1. Resident #11 physician was notified of leg "Resident to be turned every one hour and PRN rests not being on per order by the Director of (as necessary) side to side in bed". Nursing(DON) on 8/12/2010. Leg rest was removed immediately per Interview on 08/11/10, at approximately 3:15 PM with the Director of Nursing (DON) revealed if the physicians order on 8/12/2010. resident had the special turning schedule on the The Facility Rehab Coordinator(FRC) was door to turn every one (1) hour, then this immediately re educated regarding physician information should have been included on the notification and following physicians orders by the DON on 8/12/2010. Comprehensive Care Plan. 483.20(k)(3)(i) SERVICES PROVIDED MEET F 281 F 281 PROFESSIONAL STANDARDS SS≃D 2 All residents have the potential to be affected..DON and /or UM(Unit Manager) and The services provided or arranged by the facility FRC to complete an audit of all physicians must meet professional standards of quality. orders and compare orders to residents and Comphrehensive Care Plan to identify residents with orders not being followed and /or This REQUIREMENT is not met as evidenced Comphrehensive Care plan not correct and/or being followed by 9/21/2010. Based on observation, interview, and record Any resident identified w ith orders that are not review it was determined the facility falled to being followed and /or Comphrehensive Care follow Physician's Orders for one (1) of sixteen Plan is not correct will be immediately reported (16) sampled residents (Resident #11). to the physician, and /or Medical Director and orders implimented and Comphrehensive Care The findings include: Plan corrected immediately by 9/21/2010. DON/UM and/or ETD to complete a one time Review of Resident #11's medical record revealed audit of physicians orders and C.N.A care plan diagnoses which included status post Left Hip and Comphrehensive Care Plan to identify any Arthoplasty. Review of the Quarterly Minimum resident who does not have correct order Data Set (MDS) dated 05/17/10, revealed the facility assessed the resident to require extensive reflected on plan of care by 9/22/2010. Any assistance with transfers and as being unable to resident identified who has a plan of care that

ambulate. Review of the Physician's Orders

#11 to have a left elevating leg rest to his/her

revealed an order dated 03/01/10, for Resident

does not match physicians orders will be

immediately corrected, staff will be re educated

immediately and plan of care updated by the DON/UM and /or UM by 9/22/2010.

PRINTED: 08/25/2010 FORM APPROVED

STATEMEN	IT OF DEFICIENCIES	(VI) PROVINCIPIOUS ISSUED				OMB NO	0938-0391
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		ОТГ	TEST ADDRESS OF A STATE OF THE	U0/1	2/2010
STANTO	ON NURSING CENTER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE			
	T BURGASIA	•		S	STANTON, KY 40380		
(X4) ID PREFIX TAG	REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRINCENCY)	ULD BE OPRIATE	(X5) COMPLETION DATE
F 282 SS=D	wheelchair. Observation on 08/08/12/10, at 8:35 Al 12:30 PM revealed in a wheelchair with Interview on 08/12/1 Nursing Assistant (CResident #11 that di Plan indicated the relevating left leg resident with Interview on 08/12/1 Therapy Manager rephysician's Order the elevating left leg resistated however, Resident wheelchair. There must have been part in regards to ha discontinue the left left interview on 08/12/1 with the Director of Naccording to the Physhould have had an his/her wheelchair. The interview on 08/12/1 with the Director of Naccording to the Physhould have had an his/her wheelchair. The improved an ordination of the continued to discontinued to dis	11/10, at 5:50 PM and M, 9:45 AM, 11:50 AM, and Resident #11 to be sitting up no legs rests. 10, at 11:55 AM with Certified CNA) #2, who was caring for ay, revealed the CNA Care esident was to have an st on his/her wheelchair. 10, at 12:07 PM with the everaled according to the resident should have an st on his/her wheelchair. She sident #11 had improved and e left elevating leg rest on The Therapy Manager stated on an oversight on Therapy's ving the Physician eg rest. 0, at approximately 3:37 PM Nursing (DON) revealed relevating left leg rest on She stated if Resident #11 ler should have been use the left leg rest. VICES BY QUALIFIED RE PLAN	F 28	32	3.DON and /or UM and FRC to vi residents to ensure physicians order and reflected on C.N.A care plan and Comphrehensive Care plan and the Comphrehensive Plan of Care is be 2 x week x 2 weeks, then 1 x week beginning week of 9/20/2010. DON and /or UM to complete an a C.N.A. care plans and Comprehens Plans to ensure care is being proviphysicians orders and that staff are following orders weekly x 4 weeks monthly x one month beginning weeks monthly x one month beginning weeks monthly x one month beginning weeks monthly x one following physicians orders by ETD and FRC regarding policy a for following physicians orders by ETD and /or UM to re educate all referably personnel regarding follow and procedure for following physic 9/20/2010. ETD/DON to re educate all nursing follow C.N A plan of care and Com Care Plan and that this is reflective orders by 9/21/2010. RDCS to randomly audit 10 Complementary orders are correct, being followed, 1 x monthly begin 9/20/2010 x 2 months.	sually auditers are corrected at eing followed at eing followed at weeks udit of 10 sive Care ded per aware and then biseek of ming Director of procedur 9/20/2010; aursing and wing policy cians order g staff to aphrehensive of physician hrehensive ans orders to the to the	ed or re by
1	must be provided by	d or arranged by the facility qualified persons in h resident's written plan of			Quality Assurance Committee for r revision if needed bi monthly x 2 m monthly beginning week of 9/20/20 present audit findings and visual au and team to make recommendation physicians orders are correct and be	nonths then 110.DON to dit findings as to ensure	
RM CMS-256	7(02-99) Previous Versions O	bsolete Event ID: 645011			and Comphrehensive Care Plan is of		7U

PRINTED: 08/25/2010 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER STANTON NURSING CENTER STANTON NURSING CENTER STANTON NURSING CENTER STANTON NURSING CENTER STREET ADDRESS, CITY, STATE, 2P CODE 31 DERICKSON LANE STANTON, KY 49890 FROVIDERS PLAN OF CORRESPOND FROM REACH DEPRICATION Waster for PROCESSED BY PULL REGULATION OR LSC IDENTIFYING INFORMATION) F 282 Continued From page 4 This RECQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure care was provided in accordance with the Comprehensive Care Plan for one (1) of skideen (16) sampled residents (Resident #11). The findings include: Review of Resident #11's medical record revealed diagnoses which included status post Left Hip Arthoplasty. Review of the Quarterly Minimum Data Set (MDS) dated 05/17/10, revealed the facility assessed the resident or require extensive assistance with transfers and as being unable to ambulate. Review of Resident #11's Comprehensive Care Plan, dated 03/10/10, revealed a "Fall/injury Assessment: Prevention and Management Plan of Care" that indicated the resident or require extensive assistance with transfers and as being unable to ambulate. Review of Resident #11's Comprehensive Care Plan and 08/12/10, at 12:03 PM revealed Resident #11 to be sitting up in a wheelchair with no legs rests. Interview on 08/12/10, at 12:03 PM with Registered Nurse 44 revealed the Comprehensive Care Plan to identify any resident who has a Comprehensive Care Plan to identify any resident with the object on the resident of the register of his/her wheelchair. Revealed the Comprehensive Care Plan to identify any resident who has a Comprehensive Care Plan to identify any resident with the base of the physician orders and C.N.A. care plan and Comprehensive Care Plan to identify any resident who has a Comprehensive Care Plan to identify any resident who has a Comprehensive Care Plan to identify any resident who has a Comprehensive Care Plan to identify any resident who has a Comprehensive Care Plan to i	TATEMENT ID PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
NAME OF PROVIDER OR SUPPLIER STANTON NURSING CENTER STREET ADDRESS, CITY, STATE, 2IP CODE 31 DERICKSON LANE STANTON, NY 40839 F 282 Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to snaure care was provided in accordance with the Comprehensive Care Plan for one (1) of sixteen (16) sampled residents (Resident #11). The findings include: Review of Resident \$11's medical record reveated diagnoses which included status post Left Hip Arthoplasty. Review of the Quarterly Minimum Datas Set (MDS) acted 608/10/10, revealed in resident was to have a left elevating leg rest on his/her wheelchair. Observations on 08/11/10, at 12:03 PM and 08/12/10, at 12:03 PM with the Comprehensive Care Plan stated Resident #11 was to have a left elevating leg rest on his/her wheelchair. Ni Arthoplasty Care Plan stated the left leg rest should have been on the resident two heights in the Comprehensive Care Plan stated the Comprehensive Care Plan correct order wheelchair. Interview on 08/12/10, at 12:03 PM with the Therzyy Manager revealed the Comprehensive Care Plan indicated Resident #11 was to have a left elevating leg rest on his/her wheelchair. Review of the coverage of the comprehensive Care Plan stated the Comprehensive Care Plan stated the left leg rest should have been on the resident wheelchair. Interview on 08/12/10, at 12:07 PM with the Therzyy Manager revealed the Comprehensive Care Plan indicated Resident #11 should have an experimental plan of care with the Comprehensive Care Plan indicated Resident #11 should have an experimental plan of care with the DoN/UM and/or UM and FRC to visually audit 15 residents to small state provident and the Comprehensive Care Plan indicated Resident #11 should have an experimental plan of care with the context will be immediately and plan of care updated by the DoN/UM and/or UM and year powers.				1		<u> </u>		
STANTON NURSING CENTER SUMMARY GIVENESS TO EXPECTED BY FULL REGISTED BY F			185352	B. WIN	1G _		08/12	/2010
F 282 Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility falled to ensure care was provided in accordance with the Comprehensive Care Plan for one (1) of sixteen (16) sampled residents (Resident #11). The findings include: Review of Resident #11's medical record revealed diagnoses which included status post Left Hip Arthoplasty. Review of the Quarterly Minimum Data Set (MDS) dated 05/17/10, revealed the facility assessed the resident to require extensive assistance with transfers and as being unable to ambulate. Review of Resident #11's Comprehensive Care Plan, dated 05/10/10, revealed a "Fall/injury Assessment: Prevention and Management Plan of Care" that indicated the resident was to have a left elevating leg rest on his/her wheelchair. Observations on 08/12/10, at 12:03 PM with Registered Nurse #4 revealed the Comprehensive Care Plans stated Resident #11 was to have a left elevating leg rest on his/her wheelchair. RN #4 turther stated the left leg rest should have been on the resident's wheelchair. Interview on 08/12/10, at 12:07 PM with the Therapy Manager revealed the Comprehensive Care Plan stated Resident #11 was to have a left elevating leg rest on his/her wheelchair. RN #4 turther stated the left leg rest should have been on the resident's wheelchair. RN #4 turther stated the left leg rest should have been on the resident's wheelchair. Interview on 08/12/10, at 12:07 PM with the Therapy Manager revealed the Comprehensive Care plans are under the facility Review of the Comprehensive Care plan to identify under Endoward Care Plans to identify any resident who does not have or event of the resident's wheelchair. RN #4 turther stated the left leg rest should have been on the resident's wheelchair. Interview on 08/12/10, at 12:07 PM with the Therapy Manager revealed the Comprehensive Care plan to identify subjections orders and CNN A care plan and Comprehensive Care Plans to identify subjections orders and C		•			3	1 DERICKSON LANE		· · · · · · · · · · · · · · · · · · ·
This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure care was provided in accordance with the Comprehensive Care Plan for one (1) of sixteen (16) sampled residents (Resident #11). The findings include: Review of Resident #11's medical record revealed diagnoses which included status post Left Hip Arthoplasty. Review of the Quarterly Minimum Data Set (MbS) dated 05/17/10, revealed the facility assessed the resident to require extensive assistance with transfers and as being unable to ambulate. Review of Resident #11's Comprehensive Care Plan, dated 08/10/10, revealed a "Fall/injury Assessment: Prevention and Management Plan of Care" that indicated the resident was to have a left elevating leg rest on his/her wheelchair. Observations on 08/11/10, at 5:50 PM and 08/12/10, at 8:35 AM, 9:45 AM, 11:50 AM, and 12:30 PM revealed Resident #11 to be sitting up in a wheelchair with no legs rests. Interview on 08/12/10, at 12:03 PM with Registered Nurse #4 revealed the Comprehensive Care Plan stated Resident #11 was to have a left elevating leg rest on his/her wheelchair. RN #4 further stated the left leg rest should have been on the resident's wheelchair. Interview on 08/12/10, at 12:07 PM with the Therapy Manager revealed the Comprehensive Care Plan to identify and for UM and for UM and FRC to visually audit 15 residents on observance of the provisions orders and care that does not match physicians orders and care that does not match physicians orders and care that does not match physicians orders will be immediately or reflected on plan of care by 9/22/2010. Any resident who has a plan of care that does not match physicians orders will be immediately or reflected on plan of care by 9/22/2010. Any resident who has a plan of care that does not match physicians orders will be immediately or plan of care by 9/22/2010. Any resident who has a plan of care that does not match physicians orders will be immediately or plan of care by 9/2	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	
Based on observation, interview and record review it was determined the facility falled to ensure care was provided in accordance with the Comprehensive Care Plan for one (1) of sixteen (16) sampled residents (Resident #11). The findings include: Review of Resident #11's medical record revealed diagnoses which included status post Left Hip Arthoplasty. Review of the Quarterly Minimum Data Set (MDS) dated 05/17/10, revealed the facility assessed the resident to require extensive assistance with transfors and as belng unable to ambulate. Review of Resident #11's Comprehensive Care Plan of Care' that indicated the resident was to have a left elevating leg rest on his/her wheelchair. Observations on 08/11/10, at 15:50 PM and 08/12/10, at 3:35 AM, 9:45 AM, 11:50 AM, and 12:30 PM revealed Resident #11 to be sitting up in a wheelchair with no legs rests. Interview on 08/12/10, at 12:03 PM with Registered Nurse #4 revealed the Comprehensive Care Plan stated Hesident #11 was to have a left elevating leg rest on his/her wheelchair. RN #4 further stated the left leg rest should have been on the resident's wheelchair. Interview on 08/12/10, at 12:07 PM with the Therapy Manager revealed the Comprehensive Care Plan of Care by 9/22/2010. Any resident who does not have correct order reflected on plan of care by 9/22/2010. Any resident who does not have correct order reflected on plan of care by 9/22/2010. Any resident who does not have correct order reflected on plan of care by 9/22/2010. Any resident who does not have correct order reflected on plan of care by 9/22/2010. Any resident who does not have correct order reflected on plan of care by 9/22/2010. Any resident who does not have correct order reflected on plan of care by 9/22/2010. Any resident who does not have correct order reflected on plan of care by 9/22/2010. Any resident who does not have correct order reflected on plan of care by 9/22/2010. Any resident who does not have correct order reflected on plan of care by 9/22/2010. Any resident who does not have cor	F 282	Continued From pa	ge 4	F2	282	F282		
ORM CMS-2567(02-99) Previous Versions Obsolete Event ID:645011 Fac and reflected on C.N.A care plan and		by: Based on observation review it was determensure care was proposed for the findings included the findings i	on, interview and record nined the facility failed to ovided in accordance with the re Plan for one (1) of sixteen ents (Resident #11). #11's medical record revealed cluded status post Left Hip w of the Quarterly Minimum ted 05/17/10, revealed the resident to require extensive as being unable to of Resident #11's re Plan, dated 08/10/10, any Assessment: Prevention lan of Care" that indicated the e a left elevating leg rest on #11/10, at 5:50 PM and M, 9:45 AM, 11:50 AM, and Resident #11 to be sitting up no legs rests. #10, at 12:03 PM with 4 revealed the re Plan stated Resident #11 levating leg rest on his/ner further stated the left leg rest in the resident's wheelchair.			rests not being on per order by the Nursing(DON) on 8/12/2010. Leg rest was removed immediately physicians order on 8/12/2010. The Facility Rehab Coordinator(Fimmediately re educated regarding notification, following physicians following the Comprehensive Plant DON on 8/12/2010. Resident #11 Comprehensive Plant updated by DON on 8/13/2010. 2 All residents have the potential of DON and for UM(Unit Manager)/to complete an audit of all Comprehensive Care plant that is not and/or being followed by 9/21/20/1/20/1/20/1/20/1/20/1/20/1/20/1/	e Director of ly per PRC) was g physician orders and n of care by n of Care was to be affected ETD and FR ehensive Care as a not correct lo. ensive Care nediately Medical and ed immediate i/or ETD. e a one time I.A care plan dentify any t order 010.Any of care that will be e re educated ted by the 10. sually audit 1	the s d. C. C. e
	ORM CMS-256	67(02-99) Previous Versions	Obsolete Event ID: 645011		fac	and reflected on C.N.A care plan as	is are corrected	je 5 of 16

Comprehensive Care plan and that

beginning week of 9/20/2010.

Comprehensive Plan of Care is being followed 2 x week x 2 weeks, then 1 x week x 4 weeks

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	(X3) DATE SURVEY COMPLETED	
		185352	B. WIN	1G		08/12/2010		
	ROVIDER OR SUPPLIER N NURSING CENTER			3	REET ADDRESS, CITY, STATE, ZIP CODE 1 DERICKSON LANE TANTON, KY 40380			
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE IOPRIATE	(X6) COMPLETION DATE	
SS=D	elevating left leg res According to the Th no longer needed th had improved. Interview on 08/12/1 with the Director of ic Comprehensive Car should have an elev wheelchair. The DC should have a left le She stated if Reside Comprehensive Car revised to include th 483.25 PROVIDE C HIGHEST WELL BE Each resident must provide the necessa or maintain the high mental, and psychos accordance with the and plan of care. This REQUIREMEN by: Based on observation review, it was determ provide the necessa or maintain the high mental, and psychos sixteen (16) sampler The wound nurse's a skin revealed an ope shin, which was cove	at on his/her wheelchair. erapy Manager, the resident he leg rest as his/her condition IO, at approximately 3:37 PM Nursing (DON) revealed the re Plan indicated Resident #11 rating left leg rest on his/her ON further stated the resident reg rest on his/her wheelchair. Font #11 had improved the re Plan should have been his information. ARE/SERVICES FOR EING receive and the facility must ray care and services to attain est practicable physical, social well-being, in comprehensive assessment T is not met as evidenced on, interview, and record nined the facility failed to ray care and services to attain est practicable physical, social well-being for one (1) of d residents (Resident #5). Resessment of Resident #5's en area on the resident's right ered with a Band-Ald. This		309	Charge nurse to audit 2 residents C Care Plans, compare to C.NA care ensure plan of care is correct and b 5 x week x 2 weeks then 2 x week beginning week of 9/20/2010. ETD and /or UM to re educate all a therapy personnel regarding implerevising and following Compreher Care by 9/20/2010. ETD/DON to re educate all nursing follow C.N A plan of care and Cor Care Plan and that this is reflective orders by 9/21/2010. RDCS to randomly audit 10 Comp Care Plans and compare to physici ensure orders are correct, being for that Comprehensive Care Plan is covered being followed, I x monthly beging 9/20/2010 x 2 months. 4. All audit findings to be presented Quality Assurance Committee for revision if needed bi monthly x 2 monthly beginning week of 9/20/2 present audit findings and visual a and team to make recommendation physicians orders are correct and be and Comprehensive Care Plan is covered by the covered by t	plan and eing follow x 2 weeks nursing and ementing, asive Plan of physicial rehensive ans orders to llowed and orrect and aning week of to the review and nonths then 010.DON to udit findings to ensure the eing follow orrect and anthly then	f ns	
	skin revealed an ope shin, which was cove	assessment of Resident #5's en area on the resident's right ered with a Band-Ald. This ented in the required section						

F 309 Continued From page 6 of the resident's clinical record, the Treatment Administration Record. The findings include: Review of Resident #5's medical record revealed the resident was admitted on 04/29/02, with diagnoses which included Coronary Artery TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 309 1.Resident #5 physician was notified of open area on Right shin by L.P.N. on 8/12/2010 and treatment orders were obtained and implemented. A 100% skin audit was completed on Resident #5 and no other areas identified on 8/12/2010 by the treatment nurse.		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
STANTON NURSING CENTER STANTON NURSING CENTER STANTON, KY 40380 (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 6 of the resident's clinical record, the Treatment Administration Record. The findings include: Review of Resident #5's medical record revealed the resident was admitted on 04/29/02, with diagnoses which included Coronary Artery STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380 TREPIX TAGDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380 F 309 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 309 ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 309 II. Resident #5 physician was notified of open area on Right shin by L.P.N. on 8/12/2010 and treatment orders were obtained and implemented. A 100% skin audit was completed on Resident #5 and no other areas identified on 8/12/2010 by the treatment nurse.	L	·	185352	B. WING	<u> </u>	08/12/2010	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG F 309 Continued From page 6 of the resident's clinical record, the Treatment Administration Record. A 100% skin audit was completed on Resident #5 and no other areas identified on 8/12/2010 by the resident was admitted on 04/29/02, with diagnoses which included Coronary Artery STANTON, KY 40380 PROVIDER'S PLAN OF CORRECTION (AS) (CACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION SHOULD BE (EACH CORREC	NAME OF F	PROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STATE, ZIP CODE		
F 309 Continued From page 6 of the resident's clinical record, the Treatment Administration Record. The findings include: Review of Resident #5's medical record revealed the resident was admitted on 04/29/02, with diagnoses which included Coronary Artery PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OATE PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 309 1. Resident #5 physician was notified of open area on Right shin by L.P.N. on 8/12/2010 and treatment orders were obtained and implemented. A 100% skin audit was completed on Resident #5 and no other areas identified on 8/12/2010 by the treatment nurse.	STANTO	N NURSING CENTER					
of the resident's clinical record, the Treatment Administration Record. The findings include: Review of Resident #5's medical record revealed the resident was admitted on 04/29/02, with diagnoses which included Coronary Artery 1. Resident #5 physician was notified of open area on Right shin by L.P.N. on 8/12/2010 and treatment orders were obtained and implemented. A 100% skin audit was completed on Resident #5 and no other areas identified on 8/12/2010 by the treatment nurse.	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE COMPLÉTION	
Disease, End Stage Renal Disease, Diabetes, and Dementia. Review of the facility's Policy and Procedure on Weekly Skin Assessment revealed this assessment included a head to toe visualization of the residents' skin, with documentation of the location, type, and size of any skin impairment on the Treatment Administration Record (TAR). Further review of this policy revealed the area of skin impairment was to be monitored daily until heated, using the TAR to chart the area's treatment and progress. Observation on 08/11/10, at 2:50 PM of the head to toe skin assessment performed by Licensed Practical Nurse (LPN) #3 (who is also the facility's Wound Care Nurse) revealed an open area with the measurements of 0.6 x 0.8 x 0.1 centimeters on Resident #5's right shin that was covered with a Band-Aid. Review of Resident #5's TAR revealed no documented evidence of the open area on the resident's right shin. Review of the Comprehensive Care Plan revealed no documented evidence of the area or of notification of the physician or family of the open area. Review of the physician or family of the open area. Review of the physician or family of the open area. Review of the physician or family of the open area. Review of the physician or family of the open area. Review of the physician or family of the open area. Review of the physician or family of the open area. Review of the physician or family of the open area. Review of the physician or family of the open area. Review of the physician or family of the open area. Review of the physician or family of the open area. Review of the physician or family of the open area. Review of the physician or family of the open area. Review of the physician or family of the open area. Review of the physician or family of the open area. Review of the physician or family of the open area. Review of the physician or family of the open area. Review of the physician or family of the open area. Review of the physician or family of the open area. Review of the physician or family of the open area.	F 309	of the resident's click Administration Recommented evider resident was accommented evider resident was accommented evider resident's right shir Comprehensive Care Progress Notes revedence of the area evidence of the area evidence of the evidence of the council of the residents' skin impairment was healed, using the Treatment and progress on Resident #5's right aband-Aid.	nical record, the Treatment cord. e: t #5's medical record revealed dimitted on 04/29/02, with reluded Coronary Artery e Renal Disease, Diabetes, ty's Policy and Procedure on esment revealed this ed a head to toe visualization in, with documentation of the size of any skin impairment on inistration Record (TAR). his policy revealed the area of as to be monitored daily until AR to chart the area's press. 11/10, at 2:50 PM of the head nent performed by Licensed PN) #3 (who is also the facility's e) revealed an open area with of 0.6 x 0.8 x 0.1 centimeters ght shin that was covered with the tree Plan revealed no nee of the open area on the Plan. Review of the Nurse's realed no documented as or of notification of the	F 309	1.Resident #5 physician was notifiarea on Right shin by L.P.N. on 8 treatment orders were obtained an implemented. A 100% skin audit was completed #5 and no other areas identified or the treatment nurse. 2.A one time 100% skin audit will by the DON,UM, ETD and Licens responsible for management of the to identify any skin impairment no identified by 9/20/2010. A one time audit of the Treatment Administration record will be com DON and UM to identify any known resident without treatment orders to Any open area and /or change in slidntified the DON/UM to identify assessment was completed, by who educate nurse if skin assessment of than 48 hours prior by 9/20/2010. Any change in skin status noted of without order or physician notification and will be re educated by the Deand/or ETD immediately by 9/20/2010. 3.DON and /or ETD to re educate Nurses regarding skin policy, that intervention, identification of and any open area and reporting any change in condition by 9/20/2010. ETD to re educate all C.N.A's regarder reporting any change in condition policy, which includes prevention,	on Resident on Area on on Policy on And Skin on Resident on Reside	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER N NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380				
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F 314 SS=D	the Physician's Ord documentation of trarea to Resident #5 Interview on 08/11/1 (Wound Care Nurse skin lesion on Resident esion on Resident esion on Resident esion on the Pi LPN #3 indicated the dealing with resident assessment, documentation of the Pi LPN #3 indicated the dealing with resident assessment, documentation of the Pi LPN #3 indicated the dealing with resident esident esident esident #5 in policies and proceduresident in regards to right shin. She state been recorded on the Comprehensive Carupdated with the infestiould have been resident, the facility who enters the facility who enters the facility who enters the facility who enters the facility were unavoidated pressure sores received.	ers revealed no eatment orders for the open 's right shin. 10, at 3:00 PM with LPN #3 b) revealed this was a new lent #5's shin. Further the nurse was unable to find of this area, including hysician and resident's family, e correct procedure for t skin impairments (rentation and procurement of the order) was not done. 1) PM interview with RN) #1, the Unit Manager resides, revealed facility tures were not followed for this to the open area on his/her and the open area should have the resident's TAR, the the Plan should have been formation and the Physician cotified for treatment orders. ENT/SVCS TO RESSURE SORES rehensive assessment of a must ensure that a resident thy without pressure sores the ondition demonstrates that the order and a resident having tives necessary treatment and thealing, prevent infection and	F 309	DON and /or UM/ETD to complete skin audits weekly x 4 weeks then audits to be completed weekly x 2 ensure skin program policy and probeing followed and no skin impair present not previously identified by of 9/20/2010. DON and /or UM to audit treatment administration record 1 x weekly x bit monthly x 2 to ensure any identification policy and procedure beginning 9/20/2010. DON/UM and/or ETD to audit 5 received nurses notes to identify any condition to ensure policy followed and family notification beginning 9/20/2010. 4.All audit findings to be presented Assurance Committee for review aplan if needed bit monthly x 2 then beginning week of 9/20/2010. DON to present audit findings to and review any open areas found for and tracking beginning week of 9/20/2010. 5.Date of Compliance 9/23/2010. F314 1.Resident #4 Comprehensive Care updated to reflect every one hour ture repositioning schedule on 8/12/2010 Director of Nursing. Resident #4 experienced no change	5 random skin weeks to ocedure is ment is eginning week at 4 weeks, then iffed skin mented pering week of ecords to change d for physician week of 1 x monthly QA Committee for trending 20/2010. Plan was iming and 0 by the		
	•		···	as of 8/13/2010.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/25/2010 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 185352 08/12/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON NURSING CENTER STANTON, KY 40380 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 314 Continued From page 8 2All residents have the potential to be affected. F 314 This REQUIREMENT is not met as evidenced An audit of all Comprehensive Care Plans will by: be completed by the Director of Nursing(D.O.N.), RDCS(Regional Director of Based on observation, interview, and record review it was determined the facility failed to Clinical Services) and /or the Unit Manager ensure one (1) of sixteen (16) sampled residents (U.M.)by 9/20/2010 to identify any (Resident #4) received the necessary treatment Comprehensive Care Plan not revised as needed and services to promote healing and prevent new Any Comprehensive Care Plan not revised pressure ulcers from developing. and/or not reflective of individual needs will be immediately corrected by 9/21/2010 by RDCS. The findings include: DON and /or UM. A 100% skin audit of all residents will be Review of Resident #4's medical record revealed completed by DON,UM, Treatment Nurse and the resident had a history of healed Stage IV ETD(Education Training Director) to identify Pressure Ulcer to the right buttock, and had any area of skin impairment, any area found will current Stage Il Pressure Ulcers to his/her right be immediately reported to the phsycian, family inner elbow and coccyx. and treatment obtained per policy, this will be completed by 9/18/2010.

Review of the Quarterly Minimum Data Set (MDS) dated 07/09/10, revealed the resident required extensive assist of two persons for bed mobility and transfers. Further review of the MDS revealed the patient had current Pressure Ulcers. Review of the Resident Assessment Protocols Summary (RAPS) dated 05/19/10, revealed Resident #4 triggered for Pressure Ulcers due to he/she required extensive assist with bed mobility, was incontinent of bowel and bladder, and had current pressure ulcers.

Review of the Comprehensive Care Plan dated 08/03/10, revealed the resident had a care plan for the treatment and prevention of Pressure Ulcers. The interventions included to turn and reposition the resident, with no frequency indicated.

Observations on 08/11/10, revealed the resident to be lying on his/her bed. Continued observation revealed staff turned Resident #4 to his/her left

FORM CMS-2667(02-99) Previous Versions Obsolete

Event ID: 645011

3. Regional Director of Clinical Services (RDCS) who is Wound Care Certified, to re educate the DON, UM, ETD (Education Training Director) and licensed nurse responsible for skin program management regarding policy and procedure for turning and repositioning schedule, policy and procedure for individualized turning and repositioning schedule, policy for prevention and healing of pressure ulcers and policy and procedure for development and implementation of the individualized Comprehensive Care Plan by 9/15/2010.

A one time visual audit of all residents on both

be conducted by DON, ETD and /or UM to

repositioned per individual schedule will be

one education conducted immediately with

identified residents nurse and C.N A and

by 9/21/2010.

immediately turned and repositioned, one on

physician will be notified, this will be completed

schedule, any resident not turned and

identify any resident not turned per individual

shifts who require turning and repositioning will

9 of 16

All newly hired nursing employees will receive education regarding policy for wound prevention, turning and repositioning, following individual plan of care per Comphrehensive plan of care, and completing turning and repositioning rounds in orientation beginning 41/20/2016 AF0/20/2010

STATEMEN	IT OF DEFICIENCIES	(V4) DOOWDED (CHOOL ISSUE)			· · · · · · · · · · · · · · · · · · ·	OMB NO. 093	<u>8-039</u>
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIP LDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	,
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	PROVIDER OR SUPPLIER ON NURSING CENTER		-	31	EET ADDRESS, CITY, STATE, ZIP CODE DERICKSON LANE FANTON, KY 40380	08/12/201	10
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F 314	side at 9:30 AM. From AM, 11:53 AM, and #4 continued to be bed. Interview on 08/11/1 Nursing Assistants there was a yellow on the outside of the to the CNAs, this independent turning schewas a paper taped the door that informed the surveyor revealed turned side to side enecessary). Further revealed they had "t"every hour". Howe	urther observations at 10:55 12:45 PM revealed Resident ying on his/her left side on the O, at 2:18 PM with Certified (CNAs) #1 and #2 revealed lot with a black line through it e resident's room. According dicated the resident was on a dule. The CNAs stated there to the back of the resident's hem of the special turning of the paper the CNAs showed at Resident #4 was to be every one hour and PRN (as interview with the CNAs ried to turn" the resident wer, they indicated the Wound ther staff member had turned	F3	114	DON and /or ETD to re educat personnel regarding policy and turning and repositioning sche procedure for individualized to repositioning schedule, policy and healing of pressure ulcers procedure for development and of the individualized Compreh as relates to all plans of care by DON and /or UM to visually a to ensure turning and reposition per individualized Comprehensive Ca and being followed 5x week x week x 2 weeks beginning week x 3 month beginning 9/20/2010 to ensure POC revisioneded and that care is being p individual plan of care x 3 month beginning weeks x 3 month beginning yellow x 3 month yellow	I procedure for dule, policy and arning and for prevention and policy and implementation ensive Care Plan 1/9/21/2010. Undit ten residents ning is occurring sive Care Plan and re Plan is correct 2 weeks, then 3 x k of 9/20/2010. Omprehensive week of ed and updated as rovided per	o presentation report control
F 501 SS=D	Care Nurse revealed turning the resident of CNAs were to turn R his/her fragile skin. Interview on 08/11/16 with the Director of N resident had the spe door to turn every he been turned every or this information should comprehensive Care 483.75(i) RESPONS DIRECTOR	BILITIES OF MEDICAL	F 50)1	4 DON to present all audit find Assurance Committee (Admini of Nursing, Unit Manager, Lic responsible for skin program m Enrichment Director, Dietary S Medical Director and Social Sc for review and revision if needed and then monthly until resolved of 9/20/2010.QA Committee to of all audits and review correct order to ensure comprehensive correct and that prevention of sl policy is followed and revisions resident individual needs. QA C review all residents with pressu	strator, Director ensed Nurse anagement, Life ervices Manager, ervices Director) and bi monthly x 2 beginning week review findings ons made in care plans are kin impairment anade per committee to re areas and	
		gnate a physician to serve	·	\perp	review plan of care and revise p based on review findings bi mo	lan as needed	-
mm UMS-256	7(02-99) Previous Versions O	bsolete Event ID: 645011	i	Facility	monthly beginning week of 9/20	0/2010.	of 16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	rvey Ted
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F 501	This REQUIREMEI by: Based on interview determined the faciplace to ensure the involvement in the care policies and trin the facility. The findings includ Interview on 08/12/Regional Director of facility had a new No6/19/10. She stat Director had not attractional committee meeting 05/09. Therefore the facility had several involved in the policies and procedure of the facility had several interview on 08/12/Director #1, the for the facility had several he stated he Quality Assurance According to Medichad attended regulfacility regarding id	or is responsible for resident care policies; and the dical care in the facility. NT is not met as evidenced and record review it was litty failed to have a system in Medical Director's implementation of resident recoordination of medical care of Operations revealed the fledical Director that started ed the previous Medical ended Quality Assurance gs since the last survey in the former Medical Director was implementation of facility flures, and did not ensure the dical care in the facility. 10, at 4:15 PM with Medical mer Medical Director, revealed eral Administrators in the past was not informed of the Committee meetings. The call Director #1 prior to this he arly and gave input to the sentified concerns. Medical	F	501	1. Medical Director was made at Assurance Committee Minutes them for month of August 2010 Administrator on 9/01/2010. A Quality Assurance Meeting w 9/20/2010 and the Medical Director attend. 2. RDCS (Regional Director of and /or RDO(Regional Director attend the September Quality A Committee Meeting to identify Medical Director attending mee and procedure and ensure team understand importance of Medicoversight. 3. RDO to re educate Administration policy and procedure for Quality meetings and Medical Director 9/01/2010. Administrator to re educate Quality and procedure members regarding policy for Quality Assurance Meetings Director oversight by 9/5/2010. Administrator to notify Medical writing of the policy and procedure and participating in Quality Ass by 9/05/2010. Administrator to notify Medical writing of scheduled Quality Assurance at least 21 days in advoctober 2010 meeting. RDO and /or RDCS to attend Q	and approved by the vill be held by the vill be held by the vill be held by the villings per polymembers cal Director ator regarding y Assurance oversight by ality Assurand procedulard Medica. Director in lure for attenurance programme beginning uality Assurance ance beginning the villing	y uled ices) is) to e icy ding am
	had attended regul facility regarding id Director #1 stated	arly and gave input to the			October 2010 meeting.	uality Assura	

PRINTED: 08/25/2010 FORM APPROVED OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER N NURSING CENTEI	R :	STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380				
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F 514 \$S=D	Committee meetin notified when the rhe had "patients" to past year he had rocoordination of me he had not particip implementation of the past year. 483.75(I)(1) RES RECORDS-COMFLE The facility must no resident in according standards and practically org. The clinical recordinformation to idented the control of the resident's assess services provided; preadmission screen and progress notes. This REQUIREMED by: Based on interview determined the farecords for one (1 residents (Residents (Residents in post fall/Injury documents). The findings inclused the facility's written post fall/Injury documents.	ings, however he was not meetings occurred. He stated here he saw, however over the not given input into the edical care. He further stated pated in the development and policies and procedures during policies and procedures during policies and procedures during policies and procedures on each ance with accepted professional actices that are complete; ented; readily accessible; and anized. If must contain sufficient notify the resident; a record of the ments; the plan of care and in the results of any bening conducted by the State; is. ENT is not met as evidenced what and record review it was collity failed to maintain clinical of sixteen (16) sampled int #10) in accordance with the policies and procedures related to burnentation. de:	F 514	4.Quality Assurance team to redirector attendance and revise monthly beginning month of \$5. Date of Compliance 9/22/20 F514 1.Resident # 10 did not experiment of the condition following the falls 7/03/2010 and 7/7/2010. Medical Director was notified documentation not being corregarding Resident#10 on 9/22 DONor UM to audit all falt following a fall beginning 9/22/2010 to identify if licent following policy and procedure for following policy and procedure for foll and documentation after a falt immediately re educated by Medical Records to ensure a assessments are filed in clinical policy by 9/16/2010. All residents have the potent and IDT (Interdisciplinary Talls x 4 weeks to ensure apis completed and documente clinical record to identify an beginning week of 9/15/2010	e plan as needs September 201 2010.	ed 10. Inge of fall licy ment any fall ment e UM. per ted wall ssment e	
	Review of the fact Post Fall or Injury	ility's "Fall/Injury Management- " Policy/Procedure dated 01/09,	İ	79			

Facility ID: 100445

ATEMENT OF DEFICIENCIES (X1) PROVIDERSUPPLIENCIA DENTIFICATION NUMBER: 185362 ABULING B. WING B. W	DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/25/2010 APPROVED
NAME OF PROVIDER OR SUPPLIER STANTON NURSING CENTER STANTON NURSING CENTER STANTON, KY 40380 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) For the revealed the facility would continue documentation for seventy-two (72) hours on each shift after a resident experienced a fall or injury. Review of Resident #10's record revealed the resident experienced a fall on 08/29/10, at 4:45 PM. However, there was no documented evidence the facility implemented their policy, related to falls on 07/01/10 and 07/02/10. Also, there was no evidence the facility followed their policy durling the 7:00 AM to 7:00 PM shift on 07/03/10. Record review revealed Resident #10 experienced two (2) falls on 07/03/10, one (1) at 5:00 PM and another at 9:00 PM. However, there was no documentation on the 7:00 PM to 7:00 AM shift on 07/03/10, or on the 7:00 AM to 7:00 PM shift on 07/03/10, or on the 7:00 AM to 7:00 PM shift on 07/03/10, or on the 7:00 AM to 7:00 PM shift on 07/03/10, or on the 7:00 AM to 7:00 PM shift on 07/03/10, or on the 7:00 AM to 7:00 PM shift on 07/03/10, or on the 7:00 AM to 7:00 PM shift on 07/03/10, or on the 7:00 AM to 7:00 PM shift on 07/03/10, or on the 7:00 AM to 7:00 PM shift on 07/03/10, or on the 7:00 AM to 7:00 PM shift on 07/03/10, or the 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM shift on 07/03/10, or the 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM shift on 07/03/10, or the 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM shift on 07/03/10, or the 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM shift on 07/03/10, or the 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM shift on 07/03/10, or the 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM shift on 07/03/10, or the 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM shifts on 07/03/10, or the 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM shift on 07/03/10, or the 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM shift on 07/03/10, or the 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM shift on 07/03/10, or the 7:00 AM to 7:00 PM and 7:0	ATEMEN	TOF DEFICIENCIÉS	(X1) PROVIDER/SUPPLIER/CLIA	1	•	(X3) DATE S	
STRANTON NURSING CENTER STANTON NURSING CENTER STANTON, KY 40380 PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) F 514 Continued From page 12 revealed the facility would continue documentation for seventy-two (72) hours on each shift after a resident experienced a fall on 08/29/10, at 4:45 PM. However, there was no documented evidence the facility implemented their policy, related to falls on 07/01/10 and 07/02/10. Also, there was no evidence the facility followed their policy during the 7:00 AM to 7:00 PM and another at 9:00 PM. Thowever, there was no documented evidence of the required fall follow-up documentation on the 7:00 PM to 7:00 AM shift on 07/03/10, or on the 7:00 PM to 7:00 AM shift on 07/03/10, or on the 7:00 PM to 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM shift on 07/07/10, at 6:00 PM. Review of the record revealed no documented evidence of the follow-up to this fall on the 7:00 PM to 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM shift on 07/07/10, at 6:00 PM. Review of the record revealed no documented evidence of the follow-up to this fall on the 7:00 PM to 7:00 AM shift on 07/07/10, at 6:00 PM. To 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM shift on 07/07/10, at 6:00 PM. To 7:00 PM and 7:00 PM to 7:00 AM shift on 07/07/10, at 6:00 PM. To 7:00 PM and 7:00 PM to 7:00 AM shift on 07/07/10, at 6:00 PM. To 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM shift on 07/07/10, at 6:00 PM. To 7:00 PM. To 7:0		•	185352	B. WING		08/1	2/2010
F 514 F 514 Continued From page 12 revealed the facility would continue documentation for seventy-two (72) hours on each shift after a resident experienced a fail or injury. Review of Resident #10's record revealed the resident experienced a fail or 06/29/10, at 4:45 PM. However, there was no evidence the facility implemented their policy, related to falls on 07/01/10 and 07/02/10. Also, there was no evidence the facility followed their policy during the 7:00 AM to 7:00 PM and another at 9:00 PM. However, there was no documented evidence of the follow-up documentation on the 7:00 PM to 7:00 AM shift on 07/03/10, or on the 7:00 AM to 7:00 PM shift on 07/07/10, at 6:00 PM. Review of the record revealed no documented evidence of the follow-up to this fall on the 7:00 PM to 7:00 AM shift on 07/07/10, or the 7:00 AM shifts on 07/08/10.				3	I DERICKSON LANE		2/2010
revealed the facility would continue documentation for seventy-two (72) hours on each shift after a resident experienced a fall or injury. Review of Resident #10's record revealed the resident experienced a fall on 06/29/10, at 4:45 PM. However, there was no documented evidence the facility implemented their policy, related to falls on 07/01/10 and 07/02/10. Also, there was no evidence the facility followed their policy during the 7:00 AM to 7:00 PM shift on 07/03/10. Record review revealed Resident #10 experienced two (2) falls on 07/03/10, one (1) at 5:00 PM and another at 9:00 PM. However, there was no documented evidence of the required fall follow-up documentation on the 7:00 PM to 7:00 AM shift on 07/03/10, or on the 7:00 PM to 7:00 AM shift on 07/04/10. Further review of the record revealed the resident experienced another fall on 07/07/10, at 6:00 PM. Review of the record revealed no documented evidence of the follow-up to this fall on the 7:00 PM to 7:00 AM shift on 07/07/10, or the 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM shift on 07/07/10, or the 7:00 AM shifts on 07/08/10.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE E APPROPRIATE	(X6) COMPLETION DATE
Interview on 08/12/10, at 11:20 AM with Licensed Practical Nurse #7, the Unit Manager on which the resident resided, revealed when a resident experienced a fall, nurses were to perform follow-up documentation on the residents condition for seventy-two (72) hours after the fall. Interview on 08/12/10, at 2:50 PM with the Administrator and Director of Nursing (DON)		revealed the facility documentation for seach shift after a resinjury. Review of Resident resident experience PM. However, there evidence the facility related to falls on 07 there was no eviden policy during the 7:0 07/03/10. Record review revea experienced two (2) 5:00 PM and another was no documented follow-up documenta AM shift on 07/03/10 PM shift on 07/04/10 Further review of the experienced another Review of the record evidence of the follow PM to 7:00 PM and 7:00 07/08/10. Interview on 08/12/10 Practical Nurse #7, the resident resided, experienced a fall, no follow-up documental condition for seventy Interview on 08/12/10 Interview on 08/12/1	would continue seventy-two (72) hours on sident experienced a fall or #10's record revealed the d a fall on 06/29/10, at 4:45 e was no documented implemented their policy, 7/01/10 and 07/02/10. Also, ice the facility followed their in AM to 7:00 PM shift on aled Resident #10 falls on 07/03/10, one (1) at er at 9:00 PM. However, there is evidence of the required fall ation on the 7:00 PM to 7:00 0, or on the 7:00 AM to 7:00 0, or on the 7:00 AM to 7:00 on 07/07/10, at 6:00 PM. If revealed no documented w-up to this fall on the 7:00 on 07/07/10, or the 7:00 AM PM to 7:00 AM shifts on 0, at 11:20 AM with Licensed he Unit Manager on which revealed when a resident urses were to perform ation on the residents e-two (72) hours after the fall. 0, at 2:50 PM with the	F 514	3.DON and /or ETD to re ed nurses regarding fall policy after a fall by 9/9/2010. DON and/or UM to audit all following a fall to ensure lice following fall policy and proassessment and follow up do beginning 9/2/2010 thru 9/22 falls will be audited x 2 weel of 9/22/2010. ETD to re educate nursing strisk, policy and procedure fof fall and maintaining clinical by 9/20/2010. 4.All audit finding to be pressurance team for review at needed bi monthly x 2 then makes of 9/22/2010.DON to peducation and follow up in someetings beginning week of	falls for 72 hour ensed nurses are occdure for occumentation 2/2010, then 50% ks beginning wer aff regarding fall or follow up after records per policities tented to Quality and revision if nonthly beginning oresent any re cheduled QA 59/20/2010.	on s of ek l a y

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		4	A. BUILDING			
		185352	B. WING		08/12/2	010
. •	ROVIDER OR SUPPLIER N NURSING CENTER		31	EET AODRESS, CITY, STATE, ZIP CODE I DERICKSON LANE TANTON, KY 40380		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE 🖂	(X6) OMPLETION DATE
F 514	Continued From pa	ge 13	F 514			
, 0,14	revealed there shot shift (7:00 AM to 7:00 AM) for seventy-two experiences a fall.	uld be documentation on each 00 PM and 7:00 PM to 7:00 o (72) hours after a resident Further interview revealed the to (72) hours of follow-up	F 314			
F 520 SS=D	06/29/10, 07/03/10, been completed as 483.75(o)(1) QAA	IBERS/MEET	F 520	F520		
	assurance committ nursing services; a facility; and at least facility's staff.	tain a quality assessment and ee consisting of the director of physician designated by the 3 other members of the		1.Medical Director was made aw Assurance Committee Minutes a them for month of August 2010 Administrator on 9/01/2010. A Quality Assurance Meeting w 9/20/2010 and the Medical Director to attend.	nd approved by the ill be held by	
	committee meets a issues with respect and assurance acti develops and imple action to correct ide. A State or the Sec disclosure of the reexcept insofar as s	ment and assurance It least quarterly to identify It o which quality assessment Vitles are necessary; and It is appropriate plans of It is appropriate plans		2.RDCS (Regional Director of Clinical Services) and /or RDO(Regional Director of Operations) to attend the September Quality Assurance Committee Meeting to identify barriers to the Medical Director attending meetings per policy and procedure and ensure team members understand importance of Medical Director oversight.		
,		s by the committee to identify deficiencies will not be used as ns.				
	This REQUIREME by:	NT is not met as evidenced				

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
-		185352	B. WII	NG		08/1	08/12/2010	
NAME OF PROVIDER OR SUPPLIER			····	•	REET ADDRESS, CITY, STATE, ZIP CODE			
STANTO	N NURSING CENTER	1		1	11 DERICKSON LANE STANTON, KY 40380		:	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTIVE TAG CROSS-REFERENCED TO THE		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 520	Based on interview determined the fac Medical Director parasurance Commit The findings includ Review of the facili Committee quarter 05/09 through 05/1 evidence of the Me Interview on 08/12/Regional Director of Medical Director of Medical Director the facility to partic meetings. She state Medical Director the Medical Director the Medical Director the former Medical Director (Medical Exparticipate in the Quanticipate in the Quanticipate in the Quanticipate in the Rethe former Medical informed of the mecome to the meeting appropriate in the participate in the participate in the mecome to the meeting appropriate in the quanticipate in the participate in the participate of the mecome to the meeting appropriate in the participate in the participate in the stated there has administrators during the stated there has a stated there has administrators during the stated there has a stated the st	and record review it was lility failed to ensure the articipated in the Quality itee meetings. e: ty's Quality Assurance (QA) ly meeting sign-in forms from 0, revealed no documented dical Director's signature. 10, at 2:30 PM with the of Operations revealed the facility had a new at was appointed in 06/10, and the QA Committee ted the facility had a new at was appointed in 06/10, and the QA Committee meetings. Ted the former Medical Director #1) did not attend and A Committee meetings. Eglonal Director of Operations, Director was telephoned and etings, however he did not ags. She indicated therefore he cipate in developing and opriate plans of action to	F	520	3.RDO to re educate Administration policy and procedure for Qualimeetings and Medical Director 9/01/2010. Administrator to re educate Quality Assurance Meeting Director oversight by 9/5/2010. Administrator to notify Medica writing of the policy and proce and participating in Quality As by 9/05/2010. Administrator to notify Medica writing of scheduled Quality A Meetings at least 21 days in ad October 2010 meeting. RDO and /or RDCS to attend C Meetings for 2 months beginning September. 4. Quality Assurance team to man Director attendance and revise monthly beginning month of S. 5. Date of Compliance 9/22/2010.	ty Assurance oversight by sality Assuran y and proced s and Medica al Director in dure for atter scurance prog al Director in assurance vance beginn Quality Assurance in month of anitor Medic plan as need eptember 20	nce ure al nding gram rance	

CENTE	TMENT OF HEALTH RS FOR MEDICARE TOF DEFICIENCIES	AND HUMAN SERVI	CES			FOR	D: 08/25/2010 MAPPROVED D: 0938-0391	
AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TPLE CONSTRUCTION NG	(X3) DATE	(X3) DATE SURVEY COMPLETED			
· · · · · · · · · · · · · · · · · · ·		185352		B. WING_		-	****	
NAME OF PROVIDER OR SUPPLIER STANTON NURSING CENTER				. 3	REET ADDRESS, CITY, STATE, ZIP CO	DDE 1 08/	08/12/2010	
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PRINTED: 08/25/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
		185352	B. WING_		08/1	10/2010	
}	ROVIDER OR SUPPLIER N NURSING CENTER		3	REET ADDRESS, CITY, STATE, ZIP CODE 1 DERICKSON LANE STANTON, KY 40380			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	HOULD BE COMPLETION		
K 000	INITIAL COMMENTS		K 000				
K 025 SS≃E	A Life Safety Code survey was initiated and concluded on 08/10/2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was an "E". K 025 NFPA 101 LIFE SAFETY CODE STANDARD		K 025	K 025 The smoke barrier in the center leads to smoke barrier in the center leads by 9/24/20 the door will ensure approved acused in smoke barriers per NFP/	10. Replacion de la composição de la com	ng are	
	Based on observati determined the faci approved access d barriers according t deficient practice at compartment and (The findings included Observation on 08/ the smoke barrier in 215 had an unappression	oors were used in smoke to NFPA standards. This lifected (1) smoke 21) residents.					
ABORATORY	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPÆSENTATIVE/S SIGN	IATURE	TITLE	<u>i</u>	(X6) DAYE	

Any deficiency statement ending with an asterisk (*) deriotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CM9-2667(02-99) Previous Versions Obsolete

Event ID:645021

Facility ID: 100445

DON

PRINTED: 08/25/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			l' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	•	,	A. BUILDIN	G 01 - MAIN BUILDING 01	
		185352	B. WING		08/10/2010
NAME OF PROVIDER OR SUPPLIER STANTON NURSING CENTER			3	REET ADDRESS, CITY, STATE, ZIP CODE 1 DERICKSON LANE STANTON, KY 40380	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLÉTION
K 000	INITIAL COMMENTS		K 000		
K 025 SS=E	concluded on 08/10 not to meet the min Code of the Federa The highest scope identified was an "NFPA 101 LIFE SA Smoke barriers are least a one half hot accordance with 8. terminate at an atriprotected by fire-rapanels and steel fra separate compartm floor. Dampers are penetrations of sme	FETY CODE STANDARD constructed to provide at ur fire resistance rating in 3. Smoke barriers may um wall. Windows are ted glazing or by wired glass ames. A minimum of two nents are provided on each not required in duct oke barriers in fully ducted, and air conditioning systems.	K 025	K 025 The smoke barrier in the center 215 will be replaced by 9/24/20 the door will ensure approved a used in smoke barriers per NFP	hall above room 10. Replacing ccess doors are
	Based on observat determined the fact approved access of barriers according deficient practice a compartment and (The findings included Observation on 08, the smoke barrier in 215 had an unapprobservation was confirector.	oors were used in smoke to NFPA standards. This ffected (1) smoke 21) residents.		TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days tollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUILI		CONSTRUCTION 01 - MAIN BUI	LDING 01	(X3) DATE SI COMPLE		
		185352	B. WING	3	· · · · · · · · · · · · · · · · · · ·	<u> </u>	08/1	0/2010
NAME OF PROVIDER OR SUPPLIER STANTON NURSING CENTER			\$	31 DE	ADDRESS, CITY, FRICKSON LANE ITON, KY 4038			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORRECTED CROSS-REFERE	S PLAN OF CORE COTIVE ACTION S NCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 025			Kö	25				
	Maintenance Direct last survey the facil doors in the smoke all access doors in interview revealed t	2010 at 11:24 AM, with the or, revealed that during the ity had been cited for access barriers and he had replaced the smoke barriers. Further he Maintenance Director had he approved access door in				·	•	
	Reference: NFPA 1 19.3.7.3 Any require constructed in	01 (2000 edition) ed smoke barrier shall be						
	accordance with Se resistance rating of not less than 1/2 Exception No. 1: W barriers shall be pe to terminate at an a accordance with Exception No. 2 to	here an atrium is used, smoke rmitted trium wall constructed in 8.2.5.6(1). Not less than two						
	in duct penetrations ducted heating, ver systems where an automatic sprinkler 19.3.5.3 has been a compartments adja	n each floor. campers shall not be required of smoke barriers in fully stillating, and air conditioning approved, supervised system in accordance with provided for smoke cent to the smoke barrier.						
K 069 SS=D	Cooking facilities a	FETY CODE STANDARD re protected in accordance	K 00	T by	he kitchen rangy 9/15/2010. Twery 6 months	The inspection	s will be sche	luled
<u>}</u>		s not met as evidenced by: and record review it was			. 229 0 11000010			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		185352	B. WING		08/1	0/2010
	ROVIDER OR SUPPLIER		31 1	ET ADDRESS, CITY, STATE, ZIP CODE DERICKSON LANE ANTON, KY 40380		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X6) COMPLETION DATE
K 069	determined, the fackitchen hood fire standard inspected according the Life Safi 11:50 PM, with the record review reverthe facility's kitcher inspected semi-ant documented inspected semi-ant properly in the every linterview on 08/10, Maintenance Direct inspected semi-ant properly in the every linterview on 08/10, Maintenance Direct inspected semi-ant properly in the every linterview on 08/10, Maintenance Direct inspected semi-ant properly in the every linterview on 08/10, Maintenance Direct inspected semi-ant properly in the every linterview on 08/10, Maintenance Direct inspected semi-ant properly in the every linterview on 08/10, Maintenance Direct inspected semi-ant properly in the every linterview on 08/10, Maintenance Direct inspected semi-ant properly in the every linterview on 08/10, Maintenance Direct inspected semi-ant properly in the every linterview on 08/10, Maintenance Direct inspected semi-ant properly in the every linterview on 08/10, Maintenance Direct inspected semi-ant properly in the every linterview on 08/10, Maintenance Direct inspected semi-ant properly in the every linterview on 08/10, Maintenance Direct inspected semi-ant properly in the every linterview on 08/10, Maintenance Direct inspected semi-ant properly in the every linterview on 08/10, Maintenance Direct inspected semi-ant properly in the every linterview on 08/10, Maintenance Direct inspected semi-ant properly in the every linterview on 08/10, Maintenance Direct inspected semi-ant properly in the every linterview on 08/10, Maintenance Direct inspected semi-ant properly in the every linterview on 08/10, Maintenance Direct inspected semi-ant properly in the every linterview on 08/10, Maintenance Direct inspected semi-ant properly in the every linterview on 08/10, Maintenance Direct inspected semi-ant properly in the every linterview on 08/10, Maintenance Direct inspected semi-ant properly in the every linterview on 08/10, Maintenance Direct inspected semi-ant properly in the every linterview on 08/10, Maintenance Direct inspected se	cility failed to ensure the uppression system was ag to NFPA standards. le: ety Code tour on 08/10/2010 at Director of Maintenance, aled no documented evidence or range hood system was being mually as required. The last ction occurred on 04/03/2009. hood systems must be mually to ensure they function not of a fire. /2010 at 11:50 PM, with the ector, revealed he was unaware	K 069			
	Reference: NFPA 9 8-2* Inspection. A the fire extinguishin hoods containing a water system shall	ng the inspection semi-annually. 96 (1998 edition) An inspection and servicing of an inspection and servicing of a constant or fire-actuated be made at least every 6 y trained and qualified persons.				